



Washington State Department of

**Health**

Washington Health Professional Services  
PO Box 47872  
Olympia WA 98504-7872

To the Practitioner of the Washington Health Professional Services (WHPS) Participant:

Please take a few moments to complete the form below. After completing the form, please mail it to the address listed above. The completed form **must** be mailed by the practitioner. If you have any questions, please call (360) 236-2880.

**Name of WHPS Participant:** \_\_\_\_\_  
(PLEASE PRINT)

<b>Prescription Information</b>			
DATE OF PRESCRIPTION	TYPE OF MEDICATION	QUANTITY & DOSAGE PRESCRIBED/ NUMBER OF REFILLS	REASON FOR MEDICATION

**I have been informed this patient is in recovery for chemical dependency.**

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PRACTITIONER NAME (PLEASE PRINT)

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PRACTITIONER SIGNATURE

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PRACTITIONER OFFICE PHONE NUMBER

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DATE